

May 30, 2023

COALITION MEMBERS

**American Academy of Hospice
and Palliative Medicine**
(AAHPM)

**Association of
Professional Chaplains**
(APC)

**Center to Advance
Palliative Care**
(CAPC)

**HealthCare
Chaplaincy Network**
(HCCN)

**Hospice & Palliative
Nurses Association**
(HPNA)

**National Association for
Home Care & Hospice**
(NAHC)

**National Hospice and
Palliative Care Organization**
(NHPCO)

**National Palliative
Care Research Center**
(NPCRC)

**National Partnership for
Healthcare and Hospice
Innovation**
(NPHI)

**Palliative Care
Quality Collaborative**
(PCQC)

**Physician Assistants in Hospice
and Palliative Medicine**
(PAHPM)

**Social Work Hospice &
Palliative Care Network**
(SWHPN)

**Society of Pain and Palliative
Care Pharmacists**
(SPPCP)

The Honorable Chiquita Brooks-LaSure
Administrator, The Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20101

RE: CMS-1787-P Medicare Program; FY 2024 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice Quality Reporting Program Requirements, and Hospice Certifying Physician Provider Enrollment Requirements

Dear Administrator Brooks-LaSure:

On behalf of the [National Coalition for Hospice and Palliative Care](https://www.nationalcoalitionhpc.org), we welcome the opportunity to provide comments and recommendations from our Coalition [members](#) on **CMS-1787-P Medicare Program; FY 2024 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements**. To inform our comments, we drew upon the hospice expertise represented within the professional organizations that comprise our Coalition. We are pleased to offer the feedback below on behalf of our Coalition.

Our Coalition is dedicated to advancing equitable access, delivery and quality of hospice and palliative care to all those who need it. The thirteen national organizations that form the Coalition represent more than 5,500 hospice programs and their related personnel, 5,200 physicians, 1,000 physician assistants, 10,000 nurses, 5,000 chaplains, 8,000 social workers, researchers, and pharmacists, along with over 1,800 palliative care programs caring for millions of patients and families each year across the United States. We bring a broad, multidisciplinary perspective on hospice care and the changes this proposed rule will have on the vulnerable population we serve – patients and families nearing the end of life.

A. FY 2024 Hospice Wage Index and Rate Updates

The organizations in the Coalition that represent hospice providers and disciplines in hospice have shared serious concerns about the 2.8% hospice payment update, which is failing to keep pace with the rising costs hospice providers have experienced in recent years. The Consumer Price Index for All Urban Consumers (CPI-U) increased 4.9% year-over-year in April 2023.¹ We recognize that hospices

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¹ U.S. Bureau of Labor Statistics. Consumer Price Index – April 2023. May 10, 2023. Accessed from <https://www.bls.gov/news.release/pdf/cpi.pdf> on May 15, 2023.

have several unique characteristics which mean that payment rates that are inadequate for the cost of doing business impact these providers more significantly.

- The hospice per-diem payment covers all services related to the beneficiaries' terminal illness and related conditions. Costs of hospice care are highest in the first week and the last week of life. In the most recent MedPAC data, 25% of hospice patients had a length of stay of 5 days or less and 50% of patients had a length of stay of 17 days, a decrease from the previous year.² For the increasing numbers of hospices with rising numbers of short stay patients, patient care costs significantly exceed payments.
- Unlike other providers, hospices serve a high percentage of Medicare enrollees and Medicare reimbursement represents nearly 90% of a hospice provider's patient care revenue.³ Hospices rely on Medicare reimbursement as the main source of their reimbursement.

Workforce issues: Hospice providers are now seeing critical staffing shortages among nurses, social workers, aides, and other members of the interdisciplinary team. Hospices also generally need staff who have experience furnishing end-of-life care, further limiting the pool of candidates who are qualified to serve in hospice care roles. Additional concerns include burnout and an aging workforce which is reaching crisis proportions throughout health care.⁴ Due to the highly competitive marketplace, hospice providers also included retention bonuses and incentives to minimize staff vacancies. Hospices are not well positioned to compete with hospitals, staffing agencies, and other post-acute healthcare providers to recruit qualified care team members without significantly increasing their compensation costs.

- **Increases in other hospice costs:** Staffing is not the only concern for cost increases. Hospices report that the cost of medical supplies has increased by almost 20%, other operating costs have also shown increases due to inflation. Medications is also an area of significant concern, with the cost of some needed medications increasing over 50% over the previous year. These cost increases are not sustainable without an increase in Medicare payments.

Coalition Recommendation: The FY 2024 proposed market basket adjustment of 2.8% is not sufficient and will not provide adequate reimbursement that more closely matches the cost of providing care. We request that CMS look at every possible alternative to increase the market basket rate in FY 2024.

B. RFI on Hospice Utilization; Non-Hospice Spending; Ownership Transparency; and Hospice Election Decision-Making

² Medicare Payment Advisory Commission, March 2023 Report to Congress, Figure 10-2, accessed on May 15, 2023.

³ <https://www.nhpc.org/wp-content/uploads/NHPCO-Facts-Figures-2022.pdf>

⁴ Kamal AH, Wolf SP, Troy J, et al. Policy changes key to promoting sustainability and growth of the specialty palliative care workforce. Health Affairs. 2019;38(6). <https://doi.org/10.1377/hlthaff.2019.00018>

Blood transfusions, chemotherapy, radiation, and dialysis:

- 1. Are there any enrollment policies for hospices that may be perceived as restrictive to those beneficiaries that may require higher cost end of life palliative care, such as blood transfusions, chemotherapy, radiation, or dialysis? and**
- 4. Although the previously referenced analysis did not identify the cause for lower utilization of complex palliative treatments and/or higher intensity levels of hospice care, do the costs incurred with providing these services correlate to financial risks associated with enrolling such hospice patients?**

The Coalition Members discussed these questions at length and believe that the primary reason that higher cost treatments are not often provided by hospices is due to the extremely high cost of most treatments. In addition to blood transfusions, chemotherapy, radiation and dialysis, we also note there are some specialty medications that are needed to provide adequate management for some symptoms. In some cases, the monthly cost of treatments and specialty medications could range from \$4,000 to \$11,000 per month. A hospice is completely unable to cover the costs of these medications and treatments for very many patients without going bankrupt. The Coalition discussed ways that these treatments could be provided and believe that some sort of outlier payment or separate payment outside the daily rate so that patients can enroll in hospice AND concurrently receive needed treatments paid for outside the benefit. In addition to these conditions as noted by CMS there are several other conditions and diseases that have very costly palliative treatments and medications associated with them that have emerged over the past four decades since the original hospice benefit was conceived.

Coalition recommendation:

The Coalition requests that CMS work with stakeholders to review possible options for providing these high-cost treatments outside the daily rate of the hospice, through a separate payment, an outlier payment or as a part of a concurrent care benefit. The payment could be for a limited period to allow the patient to transition to hospice, such as concurrent dialysis and hospice, and would provide much needed support to the patient and their family as they enroll in hospice.

- 2. Are there any enrollment policies for hospices that may be perceived as restrictive to those beneficiaries that may require higher intensity levels of hospice care? AND**
- 4. Although the previously referenced analysis did not identify the cause for lower utilization of complex palliative treatments and/or higher intensity levels of hospice care, do the costs incurred with providing these services correlate to financial risks associated with enrolling such hospice patients? AND**
- 5. What are the overall barriers to providing higher intensity levels of hospice care and/or complex palliative treatments for eligible Medicare beneficiaries (for example, are there issues related to established formal partnerships with general inpatient/inpatient respite care facilities)? What steps, if any, can hospice providers or CMS take to address these barriers?**

The Coalition calls attention to the wording of question #2, as we believe that enrollment policies for hospices are not likely restrictive, but rather there are barriers that exist which prevent hospices from easily providing all four levels of care. The Coalition would also comment that costs incurred to these levels of care apply most often to continuous home care (CHC) rather than the other levels of care.

Continuous Home Care: Hospice providers report that the regulatory requirements for continuous home care (CHC) present the greatest difficulty. For example, a patient must receive a minimum of 8 hours in a 24-hour period that begins and ends at midnight. Often patients have symptom management issues in the evening, and unless some hours of continuous home care are provided earlier in the day, the 8 hours of care cannot be met with just evening CHC provided. Often, the mix of services is also off, as CHC must be primarily nursing services. Providers report that one additional hour of aide services in the 24-hour period meant that the requirements of CHC could not be met.

Coalition Recommendations:

- For CHC, consider what patients and families need in real life vs an arbitrary number of hours established years ago. CMS should consider a lower number of hours in a 24-hour period, such as 4 hours. Hospices would be much more likely to meet that requirement and provided needed CHC services in the home.
- Consider spreading CHC over two days to accommodate the needs of patients in the evening. Some hours could be delivered on one evening, and the remaining hours to qualify could be provided after midnight on the next day which is often the case in a “real world setting”.
- Consider changing the allowed staff to include both social workers and chaplains, where there may be a need that is not physical symptom management but rather emotional, psychosocial or spiritual care.

General Inpatient Care

Hospice providers have shared many comments about the difficulties in contracting for general inpatient care (GIP) or getting a contract GIP bed in a hospital or skilled nursing facility (SNF) and continue to meet the staffing requirements. Hospices report that often the hospital will only contract with their own health system hospice, preventing other hospice providers in the community from securing a contract for GIP there. In many cases, this hospital is the hospital of choice for patients. If a patient goes to this hospital, the hospice must discharge the patient for being “outside the service area” of the hospice, because the hospice does not have a contract. The hospice’s alternative is to negotiate a contract with another hospital some miles away, where patients and families do not want to go, but the contract meets the GIP contract regulatory requirement.

If the hospice contracts with a SNF for inpatient care, the risk is for the correct level of staffing to meet GIP requirements, or that the SNF would not have a bed available for GIP, as hospices report that beds for hospice GIP are at the bottom of the priority list.

Coalition Recommendations:

- The Coalition recommends that hospitals be strongly encouraged to contract with multiple hospices so that the hospice can meet this regulatory requirement with a hospital close by.
 - In addition, CMS should review the messages that providers hear about scrutiny in GIP so that there is clear information about what is expected at the GIP level of care and what CMS and auditors are specifically looking for in GIP audits.
- 6. What are reasons why non-hospice spending is growing for beneficiaries who elect hospice? What are ways to ensure that hospice is appropriately covering services under the benefit? AND**
 - 7. The analysis included in this proposed rule shows increased overall non-hospice spending for Part D drugs for beneficiaries under a hospice election. What are tools to ensure that hospice is appropriately covering prescription drugs related to terminal illnesses and related conditions, besides prior authorization and the hospice election statement addendum?**

The Coalition has been following the growth in non-hospice spending for several years. We believe that this is a complicated issue, where the hospice has little or no knowledge or control over the non-hospice spending due to system issues. At its core, this issue is a Medicare/CMS systems issue, where providers are not aware of the hospice election, their claims are not flagged or blocked from payment, and the hospice has no way of knowing that the spending occurred. We share a couple of examples:

- A patient goes to their regular physician for a check in. The hospice has no knowledge of the patient's visit to the doctor and the physician practice bills Medicare as they always have. The hospice will continue to have no information about the visit unless the staff proactively asks the patient and family if they have had a doctor's visit this week each time, they provide an in-person visit. Even then, it may be too late to impact the billing process so that the bill has the right modifiers or is billed to the hospice.
- The family of a patient believes that the patient needs to go to the Emergency Department despite being educated multiple times by the hospice to always "call hospice." In their anxiety and worry, they call 911, have an ambulance trip and arrive at the ED. The hospital admissions team does not check hospice enrollment, the patient receives treatment, may also have an inpatient stay. The hospice discovers the hospital admission after the fact and may or may not be able to impact or change the billing.

We note that almost half of the Part A and B spend is for physician services. Hospice clinicians evaluate each patient individually and use their professional judgment, sometimes complicated

judgment, to determine whether treatments and medications are related or not related to the patient's terminal illness and related conditions. We assert that it is impossible to evaluate whether spending in Part A or B for an individual patient is related or not related by reviewing the HCPCS coding alone. Members of the Coalition discussed examples of diagnoses or treatments where for one patient, the treatment is related to the disease progression and for another is unrelated. We believe that there may be very few HCPCS codes which are unrelated Part A or Part B spending 100% of the time. We caution CMS to continue to analyze this data with these concerns in mind.

Part D: Part D spending suffers from much of the same issue as Part A and B spend. However, CMS Part D and the National Council of Prescription Drug Programs (NCPDP) have been at work for more than 10 years to develop a way for the Part D plan to be alerted to the enrollee's hospice election through a transaction facilitator, RelayHealth. Early findings in the pilot are promising but more work is needed.

Coalition recommendations:

- Provide more education and resources to Part A and Part B providers so that “how to bill when the patient is on hospice” is readily available and easy to follow.
- Support the Part D pilot with RelayHealth and encourage its expansion.

C. Proposals and Updates to the Hospice Quality Reporting Program (HQRP)

Two new process measures: CMS intends to develop several quality measures based on information collected by the Hospice Outcome & Patient Evaluation (HOPE) instrument when it is implemented. Currently, CMS intends to develop at least two HOPE-based process and outcome quality measures focusing on the following two process measures first:

1. Timely Reassessment of Pain Impact; and
2. Timely Reassessment of Non-Pain Symptom Impact

Coalition Recommendations:

- The Coalition encourages CMS to continue to offer stakeholder engagement opportunities for these measures and future measure development.
- The Coalition is concerned about additional regulatory burden and changes in the frequency or workflow of HOPE and recommends that CMS take these concerns into account before the HOPE is released.
- Specific to the HOPE, the Coalition requests more information sharing and stakeholder involvement before CMS proposes implementation of the HOPE, as well as progress reports along the way. The Coalition and its members look forward to continued engagement with CMS, including the opportunity to receive updates about HOPE and ask clarifying questions.
- The Coalition would be pleased to host or co-sponsor an educational webinar serving to educate hospice providers, staff and patient advocacy groups before HOPE is implemented.

HOPE implementation: We understand that when HOPE is implemented hospice-wide there will be more data from which measures can be developed. In the interim, members of the Coalition read with interest the [2021 Technical Expert Panel \(TEP\) Hospice Quality Reporting Program Summary Report](#). Consistent with feedback shared from the TEP on the two process measures CMS is considering for the HQRP, the Coalition believes that reassessment of pain and non-pain symptom impact is an important process supporting the delivery of quality hospice care. Overall, the Coalition supports future HQRP process measures that build the framework for future outcome measures as we strongly believe that outcome measures are necessary in the HQRP. In both process and outcome measures it is imperative that patient preferences be incorporated.

Hospices work with patients to develop goals and interventions for the plan of care based on the assessment of the patient's needs and desires. It is not uncommon for patients to have a goal to maintain pain at a moderate or severe level for reasons related to their cultural and/or religious beliefs. They may also wish to maintain a moderate to severe impact level for pain/non-pain symptoms due to not wanting to experience some of the trade-offs (increased hours of sleep/drowsiness; inability to carry on a conversation with family, etc.) that come with the treatments necessary to reduce the impact level. Therefore, conducting a follow-up reassessment with these individuals may not be necessary and could be an annoyance and burden. The process measure calculation should exclude those situations where the patient's pain/non-pain symptoms are at or below their desired level.

Most hospices conduct follow-up for symptoms, pain and non-pain, within hours of identifying symptom impact above a patient's preference/goal. This follow-up is completed via phone, in-person visit or telehealth (two-way audio and video). If not required to be an in-person visit, CMS should consider reducing the timeframe for reassessment to one day instead of two. As a matter of practice, hospices follow-up well within the first 24 hours after symptoms are identified as above a patient's preference/goal. Depending on the symptom, initial follow-up often does not require an in-person visit.

Patients experience pain and symptoms on the physical, emotional, social and spiritual level. CMS requires hospices utilize an interdisciplinary team (IDT) in order to adequately address these levels. In situations where a patient's pain/non-pain symptoms are above their desired level, CMS should recognize reassessment by any of the appropriate IDT members.

CAHPS Hospice Survey: The Coalition was pleased when CMS shared that it was conducting a CAHPS Hospice Survey Mode Experiment. We were encouraged when results of the 2021 experiment resulted in a response rate of 39.1 percent for the web-based surveys which is 13 percentage points more than the mail-only mode. As stated in comments the Coalition has submitted in response to previous proposed rules, we encourage CMS to move with all deliberate speed on the implementation of a web-based survey.

Ethnic and language concerns for CAHPS: As the Coalition looked at the CAHPS® hospice survey through an equity lens, we are increasingly concerned that the survey might be asking the wrong questions for some ethnically diverse families. Many hospice providers note a difference in response rates between English speaking families and families that speak other languages. English-speaking families respond to the survey, while those speaking another language do not, even when the survey is translated into their language.

Coalition Recommendations:

- The Coalition requests that CMS review relative responses of English and non-English speaking individuals in other CAHPS surveys. If the same differences are present as in the hospice CAHPS survey, we request that CMS meet with stakeholders to examine methods that would encourage higher response rates for non-English speaking families in hospice.
- The Coalition recommends that great care be given to having ethnically and culturally sensitive and competent questions as the survey is translated into other languages.

Chaplain and Telehealth Visits: Three new Healthcare Common Procedure Coding System (HCPCS) codes for chaplain services were approved by CMS in late 2022. This is a positive first step towards meeting the requests of hospices and stakeholders for CMS to begin collecting data on chaplain services delivered to hospice beneficiaries. Currently, CMS collects data on all other core disciplines in hospice – physician, registered nurse, medical social worker – except chaplains (pastoral counselors) via hospice claims. This data from these other core disciplines is used in quality measures in the Hospice Quality Reporting Program (HQRP). With the approval of the HCPCS codes, delineated below, CMS would have data on all the core services of hospice care and could expand the HQRP to include chaplain services.

- HCPCS Level II code Q9001 “Assessment by chaplain services”
- HCPCS Level II code Q9002 “Counseling, individual, by chaplain services”
- HCPCS Level II code Q9003 “Counseling, group, by chaplain services”

However, it is not clear if or when CMS will utilize these codes on hospice claims or as part of the HQRP. Further guidance from CMS would be needed, i.e., defining what is considered chaplain services, and it may be necessary for CMS to identify or create a corresponding revenue code for the HCPCS codes to be utilized on hospice claims.

In its March 2022 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) urged Health and Human Services Secretary Becerra to “require that hospices report telehealth services on Medicare claims.” Throughout the COVID-19 Public Health Emergency, the *CARES Act* has granted hospice patients and providers telehealth flexibilities which have expanded access to essential post-acute care and protected the health and wellbeing of the most medically vulnerable populations. These flexibilities allow patients to take part in telehealth visits from wherever they call home and allow for the use of telehealth for low-touch, administrative face-to-face visits prior to recertification for the hospice benefit. Members of the Coalition worked to include the use of telehealth for the hospice face-to-face visit until December 31, 2024, in legislation about telehealth that passed the Congress in late 2022.

Conforming Regulations Text Revisions for Telehealth Services

CMS proposes to remove regulatory text, effective retroactively to May 12, 2023, to align with the anticipated end of the COVID-19 public health emergency (PHE). This change would eliminate the use of technology in furnishing services during a PHE, as allowed under the April 6, 2020, interim final rule titled “Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency.”

Now that the PHE has concluded, the Coalition reiterates how important technology has become for hospices providing care today, as they continue to furnish care now that the PHE has ended. Follow up visits and virtual communication with the patient and caregivers by the hospice care team adds tremendous value to the care being provided, as hospice staff establish connections with patients, provide ongoing care management, and focus on the patients’ and caregivers’ experience of care. More clarity is needed for how technology can be used for routine home care.

CMS held a national stakeholder call Office Hours call on April 25, 2023, addressing policies at the end of the PHE. On that call, CMS staff addressed a question about the use of technology for hospice visits after the PHE is over. She states that “there is nothing precluding hospices from using technology that have[sic] follow-up communication with the patient and their family as long as the use of such technology does not replace an in-person visit.” Staff goes on to provide additional information on how the use of such technology should be documented, used in accordance with standards of practice, and included in and used in accordance with the hospice’s policies and procedures. Hospice providers are pleased to have the clarification and are using the transcript from the call as their written guidance. However, the Coalition requests that additional guidance be issued, either as a transmittal or in the final rule.

¹ See <https://www.cms.gov/files/document/transcriptofficehoursendingphe04252023.pdf> and the linked recording. Accessed May 10, 2023.

Collecting telehealth information on the claim form: While the use of telehealth for the hospice face-to-face is extended until December 31, 2024, there is no way to determine its use because CMS does not require the collection of data on the hospice face-to-face or on other uses of telehealth through the hospice claim form. No consistent information on the use of telehealth, and its impact on patient access and quality, is being gathered. Hospice providers need the opportunity to reflect the full scope of care provided to patients experiencing serious illness. Right now, care delivered through telehealth is not measured, and therefore, many visits are not noted in any official record. This means that patients’ records fail to reflect the full scope of care they receive, and hospice organizations are left without a way to fully capture the quantity of their patient visits and quality of their work. An unforeseen benefit of the COVID-19 pandemic has been the rapid development of telehealth technologies and practices which help patients access care more easily, without sacrificing quality. We believe that this will be borne out by the data; and believe that collecting accurate information is critical to drafting long term policy, and effective guardrails, around the use of telehealth in the future.

Coalition Recommendations:

- The Coalition urges CMS to develop and implement any necessary revenue or other codes or modifiers for the hospice face-to-face encounter and other telehealth visits and add them to the hospice claim form.
- The Coalition requests further clarification or written communication on the use of technology outlined in the April 25, 2023, CMS Office Hours, which details the use of technology for follow-up visits as a supplement to in-person visits. Providers are using the transcript from the Office Hours call as their initial guidance but request official clarification in the final rule or through some other means.

D. Proposals Regarding Hospice Ordering/Certifying Physician Enrollment

CMS proposes that physicians who order or certify hospice services for Medicare beneficiaries be enrolled in or validly opted-out of Medicare as a prerequisite for the payment of the hospice service in question. Enrollment would be accomplished through the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) process. As proposed, this requirement would apply for the patient's designated attending physician, if any, and the hospice medical director or physician member of the interdisciplinary group (IDG) and includes all hospice certifications and recertifications. CMS states the purpose of the enrollment process is to help confirm that a physician meets all applicable Federal and state requirements and is, to an extent, a "gatekeeper" that prevents unqualified and potentially fraudulent individuals and entities from entering and inappropriately billing Medicare.

Fraudulent behavior: The Coalition strongly supports program integrity efforts to identify and terminate hospices and/or the physicians connected to them that are engaging in fraudulent behavior. However, we wish to highlight that we do not believe the change in enrollment requirements will make a significant shift in fraudulent behavior by hospices. False certifications will not be identified by the enrollment verification edit when claims are processed. Other types of fraudulent activity have been cited by CMS in the proposed rule and spotlighted by oversight entities such as the HHS OIG as well as the media involving parties other than the physician. The proposed rule identifies activities, such as paying recruiters to target beneficiaries who are not eligible for hospice care and false certifications being part of wider fraud schemes orchestrated by hospice owners and other individuals. The Coalition recognizes that having an enrollment requirement will give CMS the ability to aggressively deal with physicians who are involved in fraudulent behaviors. Therefore, we support the requirement that all physicians ordering or certifying Medicare hospice services be enrolled in PECOS or have a valid opt-out on file.

Enrollment comments: Coalition members report that some hospices currently require their employed or contracted physicians to be enrolled/validly opted-out. Other hospices (mostly smaller ones) employ or contract with physicians who are not enrolled/validly opted out. These physicians are not practicing outside their role with the hospice and, for whatever reason, do not desire to bill Medicare for their hospice services. Feedback from Coalition members is that most of these physicians would complete the enrollment or opt-out process. Most of the non-hospice

physicians designated as the attending physician by patients are enrolled or validly opted-out as part of the requirements applicable to their daily work as most of these physicians are working in a community practice or CMS-certified facility.

The enrollment application: If this proposal is finalized, most hospices will automate the PECOS verification process as other providers have done. It is our understanding that physicians will need to identify the types of services they are delivering when completing the PECOS enrollment application and that “Hospice” will be added to the list of options on the application. Nearly all types of physicians see patients that could be eligible for hospice care. These physicians are likely the ones that will refer the patient to hospice and provide the initial certification along with the hospice medical director/hospice physician and be designated by the patient as the attending physician for hospice care (the physician most involved in their care). Further, these physicians may not routinely refer patients to hospice care and do not anticipate being designated as an attending physician for hospice so will not check “Hospice” on the enrollment application.

Concerns about the list of services on the application: If the enrollment edit is set to verify that “Hospice” is a type of service the physician provides it could result in a larger than expected number of claim denials/situations in which the patient would have to sever their relationship with the physician of their choice. This could unnecessarily result in delays in patient care as hospices scramble to go back to the patient to explain that their designated attending is not able to fulfill this role and obtain certification/orders from a different attending. Therefore, the Coalition urges CMS to simply require that the hospice certifying/ordering simply be enrolled regardless of the type of services provided or the taxonomy code of the physician or be validly opted out.

Coalition Recommendations:

- The Coalition strongly supports program integrity efforts to identify and terminate hospices and/or the physicians connected to them that are engaging in fraudulent behavior. However, we do not believe the enrollment requirement will make a significant dent in fraudulent behavior by hospices. False certifications will not be identified by the enrollment verification edit when claims are processed.
- Physicians and other eligible practitioners will need to identify the types of services they are delivering when completing the PECOS enrollment application and that “Hospice” will be added to the list of options on the application. The Coalition strongly encourages education to be provided to physicians and other practitioners so that the list of services and taxonomy code for the services the physician provides is as broad as possible. This will avoid claims denials in the future.
- The Coalition strongly encourages CMS to implement this new requirement over a one-year period, so that physicians have the time needed to enroll and hospices have the time needed to adjust their internal processes.

E. Health Equity in Hospice

The Coalition appreciates CMS' attention to improving population health for all hospice patients and examining the hospice program through an equity lens. The Coalition strongly supports CMS's overall approach and goal of addressing health inequities as a foundational element across the agency and supports embedding the principles of health equity in the design, implementation, and operationalizing of policies and programs to improve health and reduce disparities for all people served by the Medicare program, including hospice.

We look forward to being partners with you in this work. The Coalition supports intentionally thinking about utilization rates within hospices to ensure that all diverse qualifying individuals and populations regardless of gender, race, ethnicity, identified or expressed gender, orientation, culture, beliefs and practices, and/or faith affiliation have access to and receive needed hospice services at the end of life.

The Coalition supports health equity principles for patients of all ages, including pediatric patients that may be covered by Medicaid or private insurance. Hospices must apply the principles of health equity and design programs and systems to reduce disparities for all patients. In the pediatric population, the Coalition recommends applying these principles in working with state Medicaid programs.

What efforts do hospices employ to measure impact on health equity?

Coalition Members have noted that there is not yet a consistent way to measure the impact of their health equity initiatives through qualitative data collection and analysis methods. There is considerable variation in the field. There is a need to provide some guidance to encourage better data collection, analysis, and examples of how actions can measure the impact of these health initiatives.

What information can CMS collect and share to help hospices serve vulnerable and underserved populations and address barriers to access?

What sociodemographic and SDOH data should be collected and used to effectively evaluate health equity in hospice settings?

The Coalition and its members recommend considering the following domains of data when collecting information on hospice beneficiaries:

- Languages other than English: Inclusion of language other than English data collection e.g., bilingual services, language competency, diversity of staff with multilingual and multicultural capabilities, music therapy in other languages, preferred language, type of interpreter services available (phone, video, or in-person).
- Was culture respected question: Inclusion of a question in data collection on whether culture was respected (potential addition to the Hospice CAHPS® Survey).
- Sexual orientation and gender identity: Inclusion of sexual orientation and gender identity.

- Expand demographic categories: Expansion of demographic categories to capture more detailed race and ethnicity information (e.g., Asian Americans broken down by region of national origin (East, Southeast, South, and other Asians) and Pacific Islanders broken down to four groups (Melanesians, Micronesians, Polynesians, and other Pacific Islanders)).
- Include a measure of SES: This could be measured by income, education and insurance status.
- Geographic data: Report geographic data for assessment of outcomes based on community deprivation index or similar measure.

Hospices have also indicated a strong need for more methods to collect information on SDOH including socioeconomic status, housing, food security, access to interpreter services, and caregiving status.

What are feasible and best practice approaches for the capture and analysis of data related to health equity?

Many providers have expressed interest in collecting better data but have noted the difficulty in data collection and analysis to measure the impact of diversity, equity, and inclusion efforts on health equity outcomes.

- **Use of CAHPS survey:** Providers have mentioned the utilization of the CAHPS survey as a way to gather diversity, equity and inclusion information to analyze feedback from the family after the patient's death. However, there is a need for more data to be gathered so hospices can identify service trends and better understand methods that have garnered the largest positive effects on health equity. Currently, the CAHPS survey does not include any information to directly assess health equity.

If the CAHPS survey is considered for this use, the survey must include enough detail and nuance to ensure inclusivity of different identities (e.g., gender identity, multiracial and ethnicity options, socioeconomic status, etc.) and strategies to address social determinants of health (SDOH). While assessment of the current domains (i.e., communication skills of providers, ease of access to health care services and patient experience) are very important for delivery of quality care, these measures need to be able to be compared across relevant demographic information. As recommended by the Institute for Healthcare Improvement¹, each hospice should collect, at a minimum, race/ethnicity, socioeconomic status, gender, and a measure of geography such as zip code or US Census tract.

- **Development of universal database:** We support the development of a universal database that will be accessible across the government and will enable programs to accurately assess the extent of the disparities and barriers that exist today and to measure progress made by hospice in promoting health equity over time. This database should be informed by stakeholder feedback to ensure the identification of the right key metrics, encourage data standardization, and incentivize investment in data collection and submission, e.g., investment by electronic medical record (EMR) and electronic health record (EHR) vendors to require interoperability when collecting these important data

points. This would also require substantial investment in post-acute providers' access to the technology necessary to assure interoperability.

- **Community assessment:** Hospices should be able to compare the demographics of the hospice's patient population to local population data to determine the hospice's reach in the community, and to identify areas for improvement and assess quality of care measures as they are rated by diverse racial and ethnic groups, diverse SES groups and diverse sexual orientation.

What barriers do hospices face in collecting information on SDOH and race and ethnicity? What is needed to overcome those barriers?

Many hospices have increased their focus on the cultural barriers perceived by hospice patients and families by embedding these discussions and topics during team meetings and identifying measurable steps to take to address these disparities.

Hospice providers report significant barriers in data collection, including:

- **Limited resources and lack of consistent and sustained organizational efforts:** Providers have noted data collection may not be a priority due to limited staff members available to administer data collection and analyze it.
- **Poorly suited Electronic Medical Record (EMR) systems:** EMR systems may not be well suited to collect accurate and detailed information on gender, sexual orientation, SES, race/ethnicity and identities. For example, it only asks participants to choose "one" option out of several races and ethnicities, which overlooks those of mixed races and ethnicities. Gender is also still binary, disregarding patients who may identify as non-binary.
- **Limitations and lack of DEI specificity in the CAHPS survey:** While providers have indicated the utilization of CAHPS report, they also noted a need to develop more data collection methods to analyze and quantify impacts on health equity. Having the CAHPS survey only as a mail or phone survey is a larger barrier to collecting data. CAHPS email availability would increase responsiveness for some, but at the same time may be a barrier to others. Utilizing email, phone and mail options may increase participation.

Hospices have begun working on ways to address barriers identified in their communities.

Reports from hospice providers include:

- Hospice providers have noted the importance of staff training and raising awareness to address barriers.
- Providers have partnered with EMR vendors for data collection to add more survey fields related to diversity, equity, and inclusion and prepare reports on health equity after data is collected.
- Hospices employ community liaisons to connect with patients informally right after admission.
- Increase the involvement of social work staff to engage in QI projects to address identified SDOH barriers to care. Social workers are trained in research and evaluation

in their training programs and should be encouraged to engage in SDOH QI projects either individually or in consultation with other members of the interdisciplinary team.

- Additionally, Z codes are available to report data on social risk, which may serve as an additional tool for collecting information on SDOHs. However, many providers see little incentive to report these codes and find that reporting of social risks fails to translate into any action to address patients' needs.

Coalition Recommendation: The Coalition recommends that CMS request that hospice organizations use SDOH Z-codes (particularly Z-55 to Z-65) to enhance quality improvement initiatives.

Thank you for your consideration of the Coalition's comments on this proposed rule. If you have questions about our comments, we would be pleased to convene experts from our Coalition to speak with you or your staff. Please contact Amy Melnick, Executive Director, National Coalition for Hospice and Palliative Care at 202.306.3590 or amym@nationalcoalitionhpc.org.

LIST OF ORGANIZATIONS

American Academy of Hospice and Palliative Medicine (AAHPM)

Association of Professional Chaplains (APC)

Hospice and Palliative Nurses Association (HPNA)

Health Care Chaplaincy Network (HCCN)

National Association for Homecare & Hospice (NAHC)

National Hospice and Palliative Care Organization (NHPCO)

National Palliative Care Research Center (NPCRC)

National Partnership for Healthcare and Hospice Innovation (NPHI)

Palliative Care Quality Collaborative (PCQC)

Physician's Assistants in Hospice and Palliative Medicine (PAHPM)

Social Work Hospice and Palliative Care Network (SWPHN)

Society of Pain and Palliative Care Pharmacists (SPPCP)

5. Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. Achieving Health Equity: A Guide for Health Care Organizations. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. (Available at ihi.org)